Title: State Option to Provide Health Homes for Enrollees with Chronic Conditions
Section: 2703
State Option

Overview: Section 2703 of the Patient Protection and Affordable Care Act (ACA) establishes a program to support states' efforts to establish health homes for Medicaid recipients with chronic conditions and/or mental health diagnoses. This provision of the ACA authorizes the Centers for Medicare and Medicaid Services (CMS) to provide states with enhanced federal funding that can be used to increase provider reimbursement rates for physicians that are recognized as a health home provider.

Health homes, also called patient centered medical homes (PCMH), could provide Medicaid recipients with more coordinated health care, improve the quality of care provided, enhance access to preventative care, and potentially result in a reduction in the cost of care. The PCMH is a health care setting that facilitates partnerships between patients and their physicians. Health home providers serve as the manager of their patients' treatment and coordinate all aspects of the patient's medical care.

Goals of a medical home are to expand access to health care, improve health outcomes, increase patient satisfaction, reduce expenditures, and decrease duplication of services. The delivery of these goals is often centered on the seven Joint Principles for Patient Centered Medical Homes,[1] which was developed in 2007 by four major primary care physician groups (American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association).

These four physician groups worked with the National Committee for Quality Assurance (NCQA) to develop a medical home recognition tool. Practices undergo a voluntary recognition process by a non-governmental entity to demonstrate that they have the capabilities to provide PCMH services. This tool assesses practices on nine different standards: access and communication;

[1] The seven principles are: (1) each patient has an ongoing relationship with a personal physician; (2) the personal physician leads a team of individuals at the practice level responsible for ongoing care of the patients; (3) the physician is responsible for meeting all of the patients' health care needs or appropriately arranging care with other qualified professionals; (4) care is coordinated and integrated across all elements of the health care system and the patients' community; (5) quality and safety are hallmarks; (6) enhanced access to care is available through systems such as open scheduling and expanded hours; and (7) payment appropriately recognizes the added value provided to patients.

patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and self improvement; and advanced electronic communications. Practices that choose to undergo this self-audit may be awarded one of three levels of recognition, with reimbursement rates potentially tied to the level of medical home accreditation achieved by the practice.

Although health homes could potentially benefit all patients, people with chronic conditions might benefit the most from a PCMH and have the greatest impact on both the quality and cost of care. This population often over-utilizes hospitals and emergency rooms, and many of these high-cost hospital visits could have been avoided if the members' care had been better managed and coordinated. Health homes are designed to address this issue, with the intent of improving the health of people with chronic conditions and decreasing the associated costs.

Targeted Populations: Section 2703 of the ACA identifies individuals with specific chronic conditions that should be included in a health homes initiative. These are common conditions that many Nevada Medicaid recipients have, and they include the following:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Overweight, as evidenced by having a Body Mass Index (BMI) over 25

In addition, recipients must meet one of the following criteria:

- 2 chronic conditions;
- 1 chronic condition and is at risk of having a second chronic condition; or,
- 1 serious and persistent mental health condition

An initial analysis of Medicaid data indicate that roughly 20,000 recipients currently covered by Nevada Medicaid's fee-for-service program could qualify for participation under the health homes initiative. In addition, the statute allows states to expand the list of chronic conditions to include other individuals who may participate in a health homes program. Our review of the data suggests that as many as 35,000 to 45,000 Medicaid fee-for-service beneficiaries with chronic conditions could benefit from a health homes initiative and be targeted for inclusion in a PCMH program.

Increasing the number of participants should result in a greater percentage of a provider's patients who may be enrolled in the health homes program, thus creating a greater incentive for providers to participate and develop their practice into a health home. Given the additional time and resources required to become certified as a health home, it would be difficult to engage providers in a health home initiative if only a handful of their patients qualified for the program. Thus, the program will be more successful if there are a larger number of recipients who are actively participating.

Fiscal Impact: The health reform legislation provides funding opportunities to incentivize both providers and patients. Under Section 2703 of the ACA, CMS will pay states to cover 90% of incentive payments to health home providers for two years. Program funds will be available starting in January 2011. [Other funding opportunities, including a member incentive program, are summarized in the sections that follow.]

Few physician offices have the resources to fully manage and coordinate patient care, especially for chronically ill and disabled patients with complex care needs. To fill these gaps, states that already have medical homes in place offer support to providers. Providers who have established their practice as a medical home may be eligible to participate in an enhanced reimbursement system. This system could include:

1. Additional payments for routine office visits to encourage providers to see their patients in person;
2. Monthly care coordination fee (per member per month) to cover the costs of additional services, technologies, and/or staff; and
3. Performance-based reimbursement that recognizes achievement of quality and efficiency goals, as well as achieves cost savings.

These additional payments allow the providers to cover the costs of providing the additional care, while rewarding them for improved health and quality outcomes. The legislation provides states with the freedom to create their own incentive programs. Although it appears that the amount of federal funds Nevada currently receives for the fee-for-service office visits would remain the same, CMS would pay 90% of incentive payments to providers.

Many physicians are also overwhelmed with the process of implementing electronic medical records (EMRs), which are an important tool in monitoring care and communicating with other providers. To support this effort, DHCFP has been able to access federal EMR funding from the American Recovery and Reinvestment Act (ARRA) to distribute to non-hospital-based physicians

whose Medicaid patient volume represents at least 30% of their total volume.[2] The health homes program could work with the EMR program to identify providers who have the electronic capabilities to serve as health homes.

Applicability to Nevada: Given the high costs associated with providing care to Nevada's Medicaid recipients with chronic conditions, this program could provide the State with an opportunity to transform Nevada's medical practices into more effective and efficient health care providers. Patients with high health care needs could receive more comprehensive care while reducing utilization and expenditures associated with avoidable hospitalizations and emergency care.

Over recent years, the cost of caring for Nevada Medicaid's Aged, Blind, and Disabled (ABD) recipients has risen much faster than the cost of caring for the State's TANF/CHAP population. While the cost per recipient has remained fairly stable for Nevada's TANF/CHAP recipients, with an increase of roughly 8% from 2000 to 2009, the cost per ABD recipient increased more than 40%. This is due in part to the complex medical and social needs of the ABD population, which are often complicated by the presence of chronic diseases and multiple co-morbidities. In addition, this group of people has a high rate of behavioral health diagnoses and is often non-compliant with medication therapy.

States generally plan on medical homes paying for themselves over time through reductions in unnecessary hospitalizations, ER use, and other high-cost services. However, medical homes should not be seen as a short-term solution, but rather as an investment in future health improvements and cost reductions. Moreover, enhancements such as improved coordination and management of care are likely to improve recipient health in ways that go beyond financial calculations. Medical homes tackle the chronic health care epidemic from all sides by rewarding physicians for providing better care and helping patients take responsibility for their own health. All of this should result in an improved health care delivery system that provides more efficient care.

Although the focus needs to be on long-term savings, some states have reported improved health outcomes and reductions in hospitalizations with their medical home programs. For example, Oklahoma's SoonerCare Choice members' emergency room utilization decreased

[2] Non-hospital-based pediatricians are eligible for ARRA EMR funds if at least 20% of their volume comes from Medicaid patients.

slightly between 2004 and 2007. This was at a time when emergency room use among Medicaid enrollees was increasing in other parts of the country.

Research has shown that a multi-disciplinary approach is one of the most effective models for successful health homes. Nevada's providers would need to be willing to significantly modify their practices to better collaborate with other health professionals. It may take time to identify providers who are able to participate in a health team. Nevada will need to decide which health home format would be most appropriate for our State before making a decision to apply for funding under Section 2703.

The patient centered medical home model requires a strong commitment from the provider community, as they must be willing to significantly improve collaboration activities. It will take time to determine whether this program can work in Nevada and assess whether the grant can support the State's goals and objectives for the creation of a health home option for Nevada's chronically ill Medicaid population. If Nevada chooses to proceed with this health home project, the State may also choose to pursue several related grant opportunities, which are summarized in the sections that follow.